No. [illegible]
5-42
17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6971

ED MAR 12 1943
Registration District No. 8200

Primary Registration District No. 8041

Registrar's No. 17

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Macon 61
(c) City or town ..... (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Isaac Young

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Male | 5. Color or race Negro | 6. (a) Single, widowed, married or divorced Married

6. (b) Name of husband or wife Emma Young

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Missouri (City, town, or county) 10 (State or foreign country)

10. Usual occupation Labor

11. Industry or business /

FATHER
12. Name Dont Know
13. Birthplace D.K. 7 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Harriet Dont Know
15. Birthplace D.K. 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Isaac Young
(b) Address Macon, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-43 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn Cem.

18. (a) Signature of funeral director Stephen & Goodding
(b) Address Macon Mo

19. (a) Feb. 20 '43 (Date received local registrar) (b) Cora B. Meuchler (Registrar's signature)

1037

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4th
year 1943 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Several years, 19 .. to ..., 19 ...;
that I last saw him alive on Jan 2, 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Myocarditis — Duration: two hours

Due to .....

Due to .....

Other conditions Cancer
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

930

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? ..... (Specify type of place) (e) Means of injury .....

23. Signature Howard Meuchler (M. D. or other)
Address Macon Date signed 2-7-43

RECEIVED
District Health Officer No. 10
District File Number 3-43-535
Date Filed ~~JAN 1 1 1943~~

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ ....., Registered Apprentice No. ....., working under my personal supervision.

Signed C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
)M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6971

Registration District No. ____ Primary Registration District No. 3041 Registrar's No. ____

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County ____
(c) City or town ____
(If outside city or town limits, write "RURAL")
(d) Street No. ____
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Isaac Young
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex m | 5. Color or race B | 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased ____ (Month) (Day) (Year)

8. AGE: Years ____ Months ____ Days ____ If less than one day ____ min.
around 94. old Slave
don't know the records.

9. Birthplace ____ (City, town, or county) (State or foreign country)

10. Usual occupation ____

11. Industry or business ____

MOTHER FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) (State or foreign country)
14. Maiden name ____
15. Birthplace ____ (City, town, or county) (State or foreign country)

16. (a) Informant ____
(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 4
year 1943 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____ 19____ to ____ 19____;
that I last saw h____ alive on ____ 19____;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ____	
Due to ____	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) ____	
Major findings: Of operations ____	
Of autopsy ____	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (c) Means of injury ____

23. Signature ____ (M. D. or other) ____
Address ____ Date signed ____